Facesheet: 1. Request Information (1 of 2)

A. The State of Wisconsin requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

B. Name of Waiver Program(s): Please list each program name the waiver authorizes.

Short title (nickname)	Long title	Type of Program	
Family Care	Family Care	PIHP;	

Waiver Application Title (optional - this title will be used to locate this waiver in the finder):
B Waiver Renewal - Family Care 2015

C. Type of Request. This is an:

☒ Amendment request for an existing waiver.

The amendment modifies (Sect/Part):
This waiver amendment adds Adams, Florence, Forest, Oneida, Taylor and Vilas counties to the Family Care program to be implemented by 12/31/17. It also adds Dane county to be implemented by 12/31/18.

The following Sections of the waiver have been modified: Part I Tribal Consultation and Program History; Section A, Part 1D; Section D: Part I.E.c.; Section D: Part I.J.b.2.v.D.; Section D: Part I.M.a.1.; Section D: Part I.M.b.; corresponding sections for P3 - P5 in the Appendix D financial projection workbook.

Requested Approval Period:(For waivers requesting three, four, or five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.)

○ 1 year ○ 2 years ○ 3 years ○ 4 years ◉ 5 years

Draft ID:WI.048.06.03

D. Effective Dates: This amendment is requested for a period of 5 years. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)
Approved Effective Date of Base Waiver being Amended: 01/01/15
Proposed Effective Date: (mm/dd/yy)
07/01/17

Facesheet: 2. State Contact(s) (2 of 2)

E. State Contact: The state contact person for this waiver is below:

Name: Diane Poole
Phone: (608) 267-4896 Ext: ☐ TTY
Fax: E-mail: diane.poole@dhs.wiscons

If the State contact information is different for any of the authorized programs, please check the program name below and provide the contact information.
The State contact information is different for the following programs:

☐ Family Care

Note: If no programs appear in this list, please define the programs authorized by this waiver on the first page of the

Section A: Program Description

Part I: Program Overview

Tribal consultation.
For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.
The SMA has a formal process for informing tribal leadership of all changes to the Medicaid state plan, including and new waiver proposals and any changes or renewals of existing waivers under 1915(b) and 1915(c). Formal tribal consultation meetings are held semiannually to brief tribal leaders on a range of activities and initiatives at the SMA.

At the mid-year consultation meeting on May 14, 2014, the SMA provided the tribal leadership with information on the process for renewal of the 1915(b) and (c) Family Care waivers. On July 30, 2014, the SMA held a stakeholder meeting to specifically announce opportunities for public input including input from tribes.

In addition to the tribal consultation requirements for the public notice, the SMA meets periodically with tribal health directors, aging directors and with a group known as the Tribal Long Term Care Services Study Group. All of the meetings provide an opportunity for the SMA to brief Tribes and to get input on waiver proposals.

Tribes are notified and have the same opportunity as other stakeholders to comment on the waiver draft posted for public comment.

FOR THIS AMENDMENT, the SMA provided the tribal leadership (at the tribal consultation meeting on November 3, 2016) with information on the process for amendment of the 1915(b) Family Care waiver and the changes (adding Adams, Dane, Florence, Forest, Oneida, Taylor and Vilas counties) being made to the waiver, and the opportunity the tribes have for input on the amendment. This information was also sent to the tribal leadership, Tribal Long Term Care Study Group and Tribal Health Directors in a letter dated October 13, 2016. The State received no comments from the tribes regarding this amendment. Due to portal field space limitations, please see attached documents for tribal feedback and State response.

Program History.
For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).
Implementation of the Family Care program began in 1998 to reform the existing fragmented long-term care system in Wisconsin. The first members were enrolled in the managed long-term services and supports program in February of 2000. For several years, Family Care operated as a pilot program in five counties serving frail elders and adults with physical and intellectual and/or developmental disabilities.

With the assistance of a Real Choice Systems Change grant awarded in September 2004, Wisconsin embarked upon a process to expand Family Care geographically beyond the five pilot counties. In early 2007, the first expansion counties began operating and about 4 years later Family Care had expanded to 57 of Wisconsin's 72 counties. The target populations and the program design remained constant during this expansion.

The SMA has implemented several improvements since 2007; however the fundamental design of the program has not changed.

As of 2014, Family Care operates in 57 counties by eight PIHPs known as Family Care Managed Care Organizations. These PIHPs are certified by the SMA and monitored by the SMA under a comprehensive contract. As of February 2014, wait lists for community-based long term services and supports were eliminated in the last of the Family Care counties. On April 21, 2014, the Governor announced plans to expand Family Care to seven additional counties in 2015. Family Care was implemented in the seven additional counties as follows: Brown (7/1/15), Door (8/1/15), Kewaunee (6/1/15), Marinette (10/1/15), Menominee (11/1/15), Oconto (6/1/15), and Shawano (9/1/15).

As of 7/1/16, Family Care will operate in Rock County.

This waiver amendment adds Adams, Florence, Forest, Oneida, Taylor and Vilas counties to the Family Care program to be implemented by 12/31/17. It also adds Dane county to be implemented by 12/31/18.

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (1 of 3)

1. Waiver Authority. The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):
   a. ☐ 1915(b)(1) - The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
      -- Specify Program Instance(s) applicable to this authority
      ☐ Family Care
   b. ☒ 1915(b)(2) - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
      -- Specify Program Instance(s) applicable to this authority
      ☒ Family Care
   c. ☐ 1915(b)(3) - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
      -- Specify Program Instance(s) applicable to this authority
      ☐ Family Care
   d. ☒ 1915(b)(4) - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).
      -- Specify Program Instance(s) applicable to this authority
      ☒ Family Care

      The 1915(b)(4) waiver applies to the following programs
      ☐ MCO
      ☒ PIHP
      ☐ PAHP
      ☐ PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
      ☐ FFS Selective Contracting program

      Please describe:

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (2 of 3)

2. Sections Waived. Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):
   a. ☒ Section 1902(a)(1) - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.

-- Specify Program Instance(s) applicable to this statute
[x] Family Care

b. [x] Section 1902(a)(10)(B) - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
-- Specify Program Instance(s) applicable to this statute
[x] Family Care

c. [x] Section 1902(a)(23) - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.
-- Specify Program Instance(s) applicable to this statute
[x] Family Care

d. [ ] Section 1902(a)(4) - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
-- Specify Program Instance(s) applicable to this statute
[ ] Family Care

e. [ ] Other Statutes and Relevant Regulations Waived - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.
-- Specify Program Instance(s) applicable to this statute
[ ] Family Care

Section A: Program Description

Part I: Program Overview

A. Statutory Authority (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
TIMELINE AND PROCESS FOR FAMILY CARE EXPANSION TO SIX COUNTIES IN 2017:

September 2016 - RFPs issued for the following Geographic Service Regions (GSRs) that incorporate 6 of the 7 expansion counties. These counties were added to existing regions:

GSR 1: Taylor
GSR 4: Vilas, Oneida, Forest and Florence
GSR 5: Adams

November 9, 2016 - RFPs due

January 2017 – PIHPs selected

March-May 2017 - Letter mailed to all current Community Integration Program (CIP) and Community Options Program (COP) participants announcing the transition from CIP and COP to Family Care (FC) and IRIS beginning July 2017. Letter invites participants to a member forum and includes a list of FAQs.

Feb-April 2017 - Letter mailed to all current CIP/COP providers inviting them to a provider forum.

Feb-May 2017 - Two public notices published in the official newspapers for each of the 6 expansion counties. One announces the provider forums and the other announces the member forums for a total of 12 notices.

Feb-April 2017 - State hosts provider forums presenting the differences between FC and IRIS. Each PIHP also provides information on their contracting and claims payment processes.

March-May 2017 - State hosts 1-2 member forums in each expansion county presenting the differences between FC and IRIS, as well as who the State is contracting with to operate both programs. Topics include: when the Aging and Disability Resource Center (ADRC) will contact individuals for options counseling, how decisions about care plans and service providers are made, appeals and grievance processes, availability of independent ombudsmen services, and when individuals will need to make a decision.

April-October 2017 - ADRCs meet with each CIP/COP participant and/or their guardian or legal representative to perform options counseling.

June-October 2017 – 30 days prior to each county's implementation date, State sends a letter to all current CIP/COP participants notifying them that their current program is terminating by the end of 2017 and that new choices are available to them. Letter includes contact information for the ADRC, as well as the ombudsmen.

TIMELINE AND PROCESS FOR FAMILY CARE EXPANSION TO DANE COUNTY IN 2018:

January 2017 - RFPs issued for Dane County, GSR 12.

March 2017 - RFPs due

May-June, 2017 – PIHPs selected

August-September 2017 - Letter mailed to current CIP/COP participants announcing the transition to FC and IRIS beginning Q1 2018. Letter invites participants to member forums and includes a list of FAQs related to the transition.

July-August 2017 - Letter mailed to all current CIP/COP providers inviting them to provider forums.

July-September 2017 - Public notices published in Dane County official newspapers announcing the provider and member forums.

July-August 2017 - State hosts 2 provider forums. State presents the differences between FC and IRIS. Each PIHP provides information on their contracting and claims payment processes.

September-October 2017 - State hosts 2 member forums. State presents the differences between FC and IRIS, as well as who the State is contracting with to operate both programs. Topics include: when the ADRC would be contacting individuals for options counseling, how decisions about care plans and service providers are made, appeals and grievance processes, availability of independent ombudsmen services, and when individuals will need to make a decision.

October 2017-June 2018 - ADRC meets with each CIP/COP participant and/or their guardian or legal representative to perform options counseling.

By December 31, 2017 - State sends letter to all current CIP/COP participants notifying them that their current program is terminating by the end of 2018 and that new choices are available to them. Letter includes ADRC contact information, as well as the ombudsmen.

PIHP'S READINESS FOR FAMILY CARE EXPANSION TO ADAMS, DANE, FLORENCE, FOREST, ONEIDA, TAYLOR AND VILAS COUNTIES:

The State considers the following factors when determining a PIHP's readiness to provide services:

* Availability of all provider types throughout the county
* Knowledge of the target groups to be served
* care management capacity, as well as tools and competency (comprehensive assessment, member-centered plan template, service authorization policy, safety and risk policy, training plan, etc.)
* Member materials
* Appeals and grievances process

* Quality management plan and activities
* Financial projections

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (1 of 3)

1. Delivery Systems. The State will be using the following systems to deliver services:

a. ☐ MCO: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.

b. ☒ PIHP: Prepaid Inpatient Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.

- ◉ The PIHP is paid on a risk basis
- ○ The PIHP is paid on a non-risk basis

c. ☐ PAHP: Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.

- ○ The PAHP is paid on a risk basis
- ○ The PAHP is paid on a non-risk basis

d. ☐ PCCM: A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.

e. ☐ Fee-for-service (FFS) selective contracting: State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards.

- ○ the same as stipulated in the state plan
- ○ different than stipulated in the state plan

Please describe:

f. ☐ Other: (Please provide a brief narrative description of the model.)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (2 of 3)

2. Procurement. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

☐ Procurement for MCO

- ○ Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ Open cooperative procurement process (in which any qualifying contractor may participate)
- ○ Sole source procurement
- ○ Other (please describe)

☒ Procurement for PIHP

- ◉ Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ Open cooperative procurement process (in which any qualifying contractor may participate)
- ○ Sole source procurement
- ○ Other (please describe)

☐ Procurement for PAHP

- ○ Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ Open cooperative procurement process (in which any qualifying contractor may participate)
- ○ Sole source procurement
- ○ Other (please describe)

☐ Procurement for PCCM

- ○ Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ Open cooperative procurement process (in which any qualifying contractor may participate)
- ○ Sole source procurement
- ○ Other (please describe)

☐ Procurement for FFS

- ○ Competitive procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- ○ Open cooperative procurement process (in which any qualifying contractor may participate)
- ○ Sole source procurement
- ○ Other (please describe)

Section A: Program Description

Part I: Program Overview

B. Delivery Systems (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (1 of 3)

1. Assurances.
   - [X] The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.
     - [ ] The State seeks a waiver of section 1932(a)(3) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.
2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

   Program: " Family Care. "
   - [ ] Two or more MCOs
   - [ ] Two or more primary care providers within one PCCM system.
   - [ ] A PCCM or one or more MCOs
   - [ ] Two or more PIHPs.
   - [ ] Two or more PAHPs.
   - [X] Other:

     please describe

     Potential beneficiaries meeting the level of care requirements for 1915 (c) waiver services have the choice between a Family Care PIHP and participation in the §1915(c) self-directed supports waiver called IRIS. IRIS is available in the same geographic service areas as Family Care. In some counties, some beneficiaries may also have the choice of more than one PIHP.

     Those enrollees eligible only for State Plan services, because they do not meet the level of care requirements for 1915 (c) waiver services, have the choice of receiving those State Plan services through the PIHP or disenrolling and receiving all state plan services through regular Medicaid if they financially qualify for Medicaid.

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (2 of 3)

3. Rural Exception.
   - [ ] The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52 (b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the

following areas ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62 (f)(1)(ii)):

4. 1915(b)(4) Selective Contracting.
   - ○ Beneficiaries will be limited to a single provider in their service area
     Please define service area.
   - ◉ Beneficiaries will be given a choice of providers in their service area

Section A: Program Description

Part I: Program Overview

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
Individuals not eligible for 1915(c) waiver services have the choice of receiving State Plan services through enrollment with a PIHP or through regular Medicaid if they are financially eligible for Medicaid. Individuals who are not eligible for enrollment in a 1915(c) waiver and who, as a result, are not eligible for Medicaid, may not receive Medicaid services through either the PIHP or fee-for-service providers.

Potential beneficiaries meeting the level of care requirements for 1915 (c) waiver services have the choice between a Family Care PIHP and participation in the §1915(c) self-directed supports waiver called IRIS. IRIS is available in the same geographic service areas as Family Care. In some counties, some beneficiaries may also have the choice of more than one PIHP.

Those enrollees eligible only for State Plan services, because they do not meet the level of care requirements for 1915 (c) waiver services, have the choice of receiving those Medicaid State Plan services through the PIHP or disenrolling and receiving all state plan services through regular Medicaid if they financially qualify for Medicaid.

Potential enrollees have any one of the following choices:

• Enrolling in a PIHP. In certain counties there may be more than one PIHP from which to choose; or

• Enrolling in IRIS (the Self-Directed Supports Waiver) for 1915 (c) waiver services while receiving State Plan services via FFS; or

• Receiving all State Plan services via FFS Medicaid if they are financially qualified for Medicaid.

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (1 of 2)

1. General. Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.
   - ▪ Statewide -- all counties, zip codes, or regions of the State
     -- Specify Program Instance(s) for Statewide
     - ☒ Family Care
   - ▪ Less than Statewide
     -- Specify Program Instance(s) for Less than Statewide
     - ☐ Family Care

2. Details. Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Douglas County	PIHP	Community Care Connections of Wisconsin
Bayfield County	PIHP	Community Care Connections of Wisconsin
Ashland County	PIHP	Community Care Connections of Wisconsin
Iron County	PIHP	Community Care Connections of Wisconsin
Price County	PIHP	Community Care Connections of Wisconsin
Sawyer County	PIHP	Community Care Connections of Wisconsin
Washburn County	PIHP	Community Care Connections of Wisconsin
Burnett County	PIHP	Community Care Connections of Wisconsin
Polk County	PIHP	Community Care Connections of Wisconsin
Barron County	PIHP	Community Care Connections of Wisconsin
Rusk County	PIHP	Community Care Connections of Wisconsin
Chippewa County	PIHP	ContinuUs; Care Wisconsin
Eau Claire County	PIHP	ContinuUs; Care Wisconsin
Dunn County	PIHP	ContinuUs; Care Wisconsin
St. Croix County	PIHP	ContinuUs; Care Wisconsin
Pierce County	PIHP	ContinuUs; Care Wisconsin
Clark County	PIHP	Western Wisconsin Cares; Care Wisconsin
Jackson County	PIHP	Western Wisconsin Cares; Care Wisconsin
Trempealeau County	PIHP	Western Wisconsin Cares; Care Wisconsin
Buffalo County	PIHP	Western Wisconsin Cares; Care Wisconsin
Pepin County	PIHP	Western Wisconsin Cares; Care Wisconsin
Monroe County	PIHP	Western Wisconsin Cares; Care Wisconsin
LaCrosse County	PIHP	Western Wisconsin Cares; Care Wisconsin
Vernon County	PIHP	Western Wisconsin Cares; Care Wisconsin
Lincoln County	PIHP	Community Care Connections of Wisconsin
Langlade County	PIHP	Community Care Connections of Wisconsin
Marathon County	PIHP	Community Care Connections of Wisconsin
Wood County	PIHP	Community Care Connections of Wisconsin
Portage County	PIHP	Community Care Connections of Wisconsin
Marinette County	PIHP	Lakeland Care District; Care Wisconsin
Oconto County	PIHP	Lakeland Care District; Care Wisconsin
Menominee County	PIHP	Lakeland Care District; Care Wisconsin
Shawano County	PIHP	Lakeland Care District; Care Wisconsin
Brown County	PIHP	Lakeland Care District; Care Wisconsin
Door County	PIHP	Lakeland Care District; Care Wisconsin
Kewaunee County	PIHP	Lakeland Care District; Care Wisconsin
Waupaca County	PIHP	Community Care, Inc.; Lakeland Care District
Outagamie County	PIHP	Community Care, Inc.; Lakeland Care District
Calumet County	PIHP	Community Care, Inc.; Lakeland Care District
Manitowoc County	PIHP	Community Care, Inc.; Lakeland Care District

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Winnebago County	PIHP	Community Care, Inc.; Lakeland Care District
Fond du Lac County	PIHP	Community Care, Inc.; Lakeland Care District
Waushara County	PIHP	Care Wisconsin; ContinuUs
Marquette County	PIHP	Care Wisconsin; ContinuUs
Green Lake County	PIHP	Care Wisconsin; ContinuUs
Columbia County	PIHP	Care Wisconsin; ContinuUs
Dodge County	PIHP	Care Wisconsin; ContinuUs
Jefferson County	PIHP	Care Wisconsin; ContinuUs
Washington County	PIHP	Care Wisconsin; ContinuUs; Community Care, Inc.; My Choice Family Care
Waukesha County	PIHP	Care Wisconsin; ContinuUs; Community Care, Inc.; My Choice Family Care
Sheboygan County	PIHP	Care Wisconsin; Community Care, Inc.; My Choice Family Care
Ozaukee County	PIHP	Care Wisconsin; Community Care, Inc.; My Choice Family Care
Walworth County	PIHP	Care Wisconsin; Community Care, Inc.; My Choice Family Care
Milwaukee County	PIHP	Community Care, Inc.; My Choice Family Care; iCare
Racine County	PIHP	Community Care, Inc.; My Choice Family Care; iCare
Kenosha County	PIHP	Community Care, Inc.; My Choice Family Care; iCare
Juneau County	PIHP	ContinuUs; Care Wisconsin
Sauk County	PIHP	ContinuUs; Care Wisconsin
Richland County	PIHP	ContinuUs; Care Wisconsin
Crawford County	PIHP	ContinuUs; Care Wisconsin
Grant County	PIHP	ContinuUs; Care Wisconsin
Iowa County	PIHP	ContinuUs; Care Wisconsin
LaFayette County	PIHP	ContinuUs; Care Wisconsin
Green County	PIHP	ContinuUs; Care Wisconsin
Rock County	PIHP	My Choice Family Care; Community Care Connections of Wisconsin
Adams County	PIHP	TBD
Dane County	PIHP	TBD
Florence County	PIHP	TBD
Forest County	PIHP	TBD
Oneida County	PIHP	TBD
Taylor County	PIHP	TBD
Vilas County	PIHP	TBD

Section A: Program Description

Part I: Program Overview

D. Geographic Areas Served by the Waiver (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (1 of 3)

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. Included Populations. The following populations are included in the Waiver Program:

- [ ] Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.
  - ○ Mandatory enrollment
  - ○ Voluntary enrollment

- [X] Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.
  - ○ Mandatory enrollment
  - ◉ Voluntary enrollment

- [X] Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.
  - ○ Mandatory enrollment
  - ◉ Voluntary enrollment

- [ ] Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.
  - ○ Mandatory enrollment
  - ○ Voluntary enrollment

- [X] Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.
  - ○ Mandatory enrollment
  - ◉ Voluntary enrollment

- [ ] Foster Care Children are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.
  - ○ Mandatory enrollment
  - ○ Voluntary enrollment

- [ ] TITLE XXI SCHIP is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children's Health Insurance Program (SCHIP) through the Medicaid program.

- ○ Mandatory enrollment
- ○ Voluntary enrollment

☐ Other (Please define):

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (2 of 3)

2. Excluded Populations. Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the "Aged" population may be required to enroll into the program, but "Dual Eligibles" within that population may not be allowed to participate. In addition, "Section 1931 Children" may be able to enroll voluntarily in a managed care program, but "Foster Care Children" within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

☐ Medicare Dual Eligible --Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

☐ Poverty Level Pregnant Women -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

☐ Other Insurance --Medicaid beneficiaries who have other health insurance.

☐ Reside in Nursing Facility or ICF/IID --Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Individuals with Intellectual Disabilities (ICF/IID).

☒ Enrolled in Another Managed Care Program --Medicaid beneficiaries who are enrolled in another Medicaid managed care program

☐ Eligibility Less Than 3 Months --Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☒ Participate in HCBS Waiver --Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

☐ American Indian/Alaskan Native --Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

☐ Special Needs Children (State Defined) --Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

☐ SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

☒ Retroactive Eligibility – Medicaid beneficiaries for the period of retroactive eligibility.

☐ Other (Please define):

Section A: Program Description

Part I: Program Overview

E. Populations Included in Waiver (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:
1) Included Populations: Section 1931 Adults and Related Populations -
Only that subset of adults in this population with disabilities who are determined through functional screening to require a nursing home or non-nursing level of care are included.

2) Excluded Populations: Participate in HCBS Waiver -
Medicaid beneficiaries who participate in a different Home and Community Based Waiver (HCBS, also referred to as a 1915 (c) waiver) are excluded, except for the HCBS waiver that runs concurrently with this §1915(b) waiver. CMS control number 0367.

Section A: Program Description

Part I: Program Overview

F. Services (1 of 5)

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

[X] The State assures CMS that services under the Waiver Program will comply with the following federal requirements:
- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

[ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

[X] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

[ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

[X] The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.
- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

Section A: Program Description

Part I: Program Overview

F. Services (2 of 5)

2. Emergency Services. In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

   [X] The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

   Emergency Services Category General Comments (optional):

   Inpatient and outpatient services needed to evaluate or stabilize an emergency condition are not a covered benefit in Family Care PIHPs. PIHPs are responsible to instruct all members on where and how to obtain emergency services not covered in the PIHP benefit package. In addition, PIHP interdisciplinary care management teams are responsible to monitor the health conditions of members and to coordinate PIHP services with primary and acute health care services members receive from other sources. This includes responsibility for referring to, or arranging for, emergency services when necessary and ensuring the availability of transportation needed to access primary and acute health care services. PIHP member handbooks are required to explain that members should access emergency medical care as they would in any case, such as by calling 911.
3. Family Planning Services. In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

   [ ] The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services.

   [ ] The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers.

   [ ] The State will pay for all family planning services, whether provided by network or out-of-network providers.

   [ ] Other (please explain):

   [X] Family planning services are not included under the waiver.

   Family Planning Services Category General Comments (optional):

   Family planning and emergency services are covered by the Medicaid State Plan available FFS.

Section A: Program Description

Part I: Program Overview

F. Services (3 of 5)

4. FQHC Services. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

   - [x] The program is voluntary, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
   - [ ] The program is mandatory and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC:
   - [ ] The program is mandatory and the enrollee has the right to obtain FQHC services outside this waiver program through the regular Medicaid Program.

   FQHC Services Category General Comments (optional):

   FQHC services are not included in the Family Care benefit. An enrollee may obtain FQHC services through the regular Medicaid Program while enrolled in this waiver program.

5. EPSDT Requirements.

   - [ ] The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

   EPSDT Requirements Category General Comments (optional):

   EPSDT services are not included under the waiver.

Section A: Program Description

Part I: Program Overview

F. Services (4 of 5)

6. 1915(b)(3) Services.

   - [ ] This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

   1915(b)(3) Services Requirements Category General Comments:

7. Self-referrals.

   - [ ] The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

   Self-referrals Requirements Category General Comments:

8. Other.

☐ Other (Please describe)

Section A: Program Description

Part I: Program Overview

F. Services (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
Family planning and emergency services are covered by the Medicaid State Plan available FFS.

Prescription drugs are carved out of the Family Care benefit.

Section A: Program Description

Part II: Access

A. Timely Access Standards (1 of 7)

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

Section A: Program Description

Part II: Access

A. Timely Access Standards (2 of 7)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.
   a. ☐ Availability Standards. The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.
      1. ☐ PCPs

         Please describe:

      2. ☐ Specialists

         Please describe:

      3. ☐ Ancillary providers

         Please describe:

      4. ☐ Dental

         Please describe:

      5. ☐ Hospitals

         Please describe:

      6. ☐ Mental Health

         Please describe:

      7. ☐ Pharmacies

         Please describe:

      8. ☐ Substance Abuse Treatment Providers

         Please describe:

      9. ☐ Other providers

         Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (3 of 7)

2. Details for PCCM program. (Continued)

b. ☐ Appointment Scheduling means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Urgent care

Please describe:

8. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (4 of 7)

2. Details for PCCM program. (Continued)

c. ☐ In-Office Waiting Times: The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ☐ PCPs

Please describe:

2. ☐ Specialists

Please describe:

3. ☐ Ancillary providers

Please describe:

4. ☐ Dental

Please describe:

5. ☐ Mental Health

Please describe:

6. ☐ Substance Abuse Treatment Providers

Please describe:

7. ☐ Other providers

Please describe:

Section A: Program Description

Part II: Access

A. Timely Access Standards (5 of 7)

2. Details for PCCM program. (Continued)

d. ☐ Other Access Standards

Section A: Program Description

Part II: Access

A. Timely Access Standards (6 of 7)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures timely access to the services covered under the selective contracting program.

Section A: Program Description

Part II: Access

A. Timely Access Standards (7 of 7)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

B. Capacity Standards (1 of 6)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

Section A: Program Description

Part II: Access

B. Capacity Standards (2 of 6)

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

a. ☐ The State has set enrollment limits for each PCCM primary care provider.

Please describe the enrollment limits and how each is determined:

b. ☐ The State ensures that there are adequate number of PCCM PCPs with open panels.

Please describe the State's standard:

c. ☐ The State ensures that there is an adequate number of PCCM PCPs under the waiver assure access to all services covered under the Waiver.

Please describe the State's standard for adequate PCP capacity:

Section A: Program Description

Part II: Access

B. Capacity Standards (3 of 6)

2. Details for PCCM program. (Continued)

d. ☐ The State compares numbers of providers before and during the Waiver.

Provider Type	# Before Waiver	# in Current Waiver	# Expected in Renewal	

Please note any limitations to the data in the chart above:

e. ☐ The State ensures adequate geographic distribution of PCCMs.

Please describe the State's standard:

Section A: Program Description

Part II: Access

B. Capacity Standards (4 of 6)

2. Details for PCCM program. (Continued)

f. ☐ PCP:Enrollee Ratio. The State establishes standards for PCP to enrollee ratios.

Area/(City/County/Region)	PCCM-to-Enrollee Ratio	

Please note any changes that will occur due to the use of physician extenders.:

g. ☐ Other capacity standards.

Please describe:

Section A: Program Description

Part II: Access

B. Capacity Standards (5 of 6)

3. Details for 1915(b)(4)FFS selective contracting programs: Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

Section A: Program Description

Part II: Access

B. Capacity Standards (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (1 of 5)

1. Assurances for MCO, PIHP, or PAHP programs

☒ The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to

the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (2 of 5)

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. [x] The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the PIHP/PAHP need not meet the requirements for additional services for enrollees with special health care needs in 42 CFR 438.208.

Please provide justification for this determination:

The State defines "persons with special health care needs" to mean any individual who is a frail elder or an adult with an intellectual disability or physical disability. Since all persons enrolled in a Family Care PIHP are "persons with special health care needs," there is no need for the PIHP to implement a process to identify "persons with special health care needs." In addition, since primary and acute health care services are carved out of the Family Care PIHP contract, there is no need for the PIHP to implement a process to assure that it effectively provides those services to "persons with special health care needs." The PIHP is required by contract to coordinate with providers that deliver primary and acute health care services to its enrollees.

b. [ ] Identification. The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State.

Please describe:

c. [ ] Assessment. Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe:

Please describe the enrollment limits and how each is determined:

d. [ ] Treatment Plans. For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan.If so, the treatment plan meets the following requirements:

1. [ ] Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee.
2. [ ] Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan).
3. [ ] In accord with any applicable State quality assurance and utilization review standards.

Please describe:

e. [ ] Direct access to specialists. If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

Please describe:

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (3 of 5)

3. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.
   a. ☐ Each enrollee selects or is assigned to a primary care provider appropriate to the enrollee's needs.
   b. ☐ Each enrollee selects or is assigned to a designated designated health care practitioner who is primarily responsible for coordinating the enrollee's overall health care.
   c. ☐ Each enrollee is receives health education/promotion information.

      Please explain:

   d. ☐ Each provider maintains, for Medicaid enrollees, health records that meet the requirements established by the State, taking into account professional standards.
   e. ☐ There is appropriate and confidential exchange of information among providers.
   f. ☐ Enrollees receive information about specific health conditions that require follow-up and, if appropriate, are given training in self-care.
   g. ☐ Primary care case managers address barriers that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
   h. ☐ Additional case management is provided.

      Please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files.

   i. ☐ Referrals.

      Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (4 of 5)

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part II: Access

C. Coordination and Continuity of Care Standards (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs

[X] The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.

[ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

[X] The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

[X] Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs.
The State assures CMS that this quality strategy was initially submitted to the CMS Regional Office on: 10/02/14 (mm/dd/yy)

[X] The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, external quality review of the outcomes and timeliness of, and access to the services delivered under each MCO/ PIHP contract. Note: EQR for PIHPs is required beginning March 2004.
Please provide the information below (modify chart as necessary):

Program Type	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO				
PIHP	MetaStar, Inc.	X	X	X

Section A: Program Description

Part III: Quality

2. Assurances For PAHP program

☐ The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☐ The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part III: Quality

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.
   a. ☐ The State has developed a set of overall quality improvement guidelines for its PCCM program.

      Please describe:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)
   b. ☐ State Intervention: If a problem is identified regarding the quality of services received, the State will intervene as indicated below.
      1. ☐ Provide education and informal mailings to beneficiaries and PCCMs
      2. ☐ Initiate telephone and/or mail inquiries and follow-up
      3. ☐ Request PCCM's response to identified problems
      4. ☐ Refer to program staff for further investigation
      5. ☐ Send warning letters to PCCMs
      6. ☐ Refer to State's medical staff for investigation
      7. ☐ Institute corrective action plans and follow-up
      8. ☐ Change an enrollee's PCCM
      9. ☐ Institute a restriction on the types of enrollees
      10. ☐ Further limit the number of assignments
      11. ☐ Ban new assignments
      12. ☐ Transfer some or all assignments to different PCCMs
      13. ☐ Suspend or terminate PCCM agreement
      14. ☐ Suspend or terminate as Medicaid providers
      15. ☐ Other

Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)
   c. ☐ Selection and Retention of Providers: This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.
   Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):
      1. ☐ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
      2. ☐ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.
      3. ☐ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):
         A. ☐ Initial credentialing
         B. ☐ Performance measures, including those obtained through the following (check all that apply):
            - ☐ The utilization management system.
            - ☐ The complaint and appeals system.
            - ☐ Enrollee surveys.
            - ☐ Other.

            Please describe:
      4. ☐ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.
      5. ☐ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).
      6. ☐ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.
      7. ☐ Other

      Please explain:

Section A: Program Description

Part III: Quality

3. Details for PCCM program. (Continued)

   d. Other quality standards (please describe):

Section A: Program Description

Part III: Quality

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (1 of 4)

1. Assurances

   [X] The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

   [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

   Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

   [X] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

   [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

A. Marketing (2 of 4)

2. Details

   a. Scope of Marketing

1. ☐ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.
2. ☒ The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general).

   Please list types of indirect marketing permitted:

   Indirect marketing materials include internet, brochures and leaflets, radio, television and print media presentations and materials in all mediums to individuals who are not currently enrolled in any of Wisconsin's long term support programs. All marketing/outreach materials must be approved by the SMA prior to distribution, per SMA PIHP Contract, Article IX, Marketing and Member Materials. Article IX, Marketing and Member Materials, Prohibited Practices, prohibits direct and indirect cold calls, either door-to-door or telephone or other cold call marketing activity are prohibited.
3. ☐ The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries).

   Please list types of direct marketing permitted:

Section A: Program Description

Part IV: Program Operations

A. Marketing (3 of 4)

2. Details (Continued)

b. Description. Please describe the State's procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ☒ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees.

   Please explain any limitation or prohibition and how the State monitors this:

   Enrollment is conducted by entities separate from the PIHPs – the Aging and Disability Resource Center which monitors for any potential gifts or incentives by the PIHPs.
2. ☐ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan.

   Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:
3. ☒ The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials.

   Please list languages materials will be translated into. (If the State does not translate or require the translation of marketing materials, please explain):

   Languages in the plan's service area spoken by 5% or more of the population. This varies across service areas. The PIHP makes this determination based on the most recent county data from the US Census Bureau or other available county specific sources.

   The State has chosen these languages because (check any that apply):

   a. ☐ The languages comprise all prevalent languages in the service area.

Please describe the methodology for determining prevalent languages:

b.

x The languages comprise all languages in the service area spoken by approximately 5 percent or more of the population.

c. ☐ Other

Please explain:

Section A: Program Description

Part IV: Program Operations

A. Marketing (4 of 4)

Additional Information. Please enter any additional information not included in previous pages:
SMA reviews and approves the PIHPs' marketing plans and all marketing materials.

PIHPs Marketing Plans must be submitted for initial certification and during annual certification if there has been a material change since last approved by the SMA. The standards for certification are set forth by rule at DHS 10.43 in the Wisconsin Administrative Code.

All marketing/outreach materials must be approved by the SMA prior to distribution, per SMA PIHP Contract, Article IX, Marketing and Member Materials.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (1 of 5)

1. Assurances

x The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

☐ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

x The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (2 of 5)

2. Details

a. Non-English Languages

1. [x] Potential enrollee and enrollee materials will be translated into the prevalent non-English languages.

Please list languages materials will be translated into. (If the State does not require written materials to be translated, please explain):

The State defines prevalent non-English languages as the languages spoken by approximately five percent or more of the potential enrollee/ enrollee population in the PIHP's geographic service area. This varies across service areas.

If the State does not translate or require the translation of marketing materials, please explain:

The State defines prevalent non-English languages as: (check any that apply):

a. [ ] The languages spoken by significant number of potential enrollees and enrollees.

Please explain how the State defines "significant.":

b. [x] The languages spoken by approximately 5.00 percent or more of the potential enrollee/enrollee population.

c. [ ] Other

Please explain:

2. [x] Please describe how oral translation services are available to all potential enrollees and enrollees, regardless of language spoken.

Live oral translators are contracted for by the PIHPs and Aging and Disability Resource Centers for prevalent languages. A telephonic translation service is available for other languages.

3. [x] The State will have a mechanism in place to help enrollees and potential enrollees understand the managed care program.

Please describe:

The Aging and Disability Resource Center as part of options counseling assists enrollees and potential enrollees to understand managed care in general and the Family Care program in particular.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (3 of 5)

2. Details (Continued)

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- ☐ State
- x ☐ Contractor

Please specify:

The State contracts with an Aging and Disability Resource Center (ADRC) in each service area to provide information to potential enrollees.

ADRCs meet state and federal requirements for organizational independence from any PIHP, as set forth in DHS 10.22 in the Wisconsin Administrative Code.

- ☐ There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP.)

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (4 of 5)

2. Details (Continued)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

- ☐ the State
- x ☐ State contractor

Please specify:

The State contracts with an Aging and Disability Resource Center (ADRC) in each service area to provide information to potential enrollees.

ADRCs meet state and federal requirements for organizational independence from any PIHP, as set forth in DHS 10.22 in the Wisconsin Administrative Code.

- x ☐ The MCO/PIHP/PAHP/PCCM/FFS selective contracting provider.

Section A: Program Description

Part IV: Program Operations

B. Information to Potential Enrollees and Enrollees (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:
PIHPs are required by contract to provide information about member rights to enrollees.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (1 of 6)

1. Assurances

- x ☐ The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C.)

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

☐ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (2 of 6)

2. Details

Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. Outreach

☒ The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program.

Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program:

The State contracts with Aging and Disability Resource Centers in each service area to serve as the single entry point for information and assistance on long-term care and other issues affecting older people, people with disabilities, or their families. ADRCs provide public information and education, outreach, information and assistance, benefit specialist services, long-term care options counseling and referral to appropriate LTC programs or providers, Family Care functional eligibility determination and level of care assessments using the State-developed automated long-term care functional screening tool, and coordination of the Family Care eligibility and enrollment processes.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (3 of 6)

2. Details (Continued)

b. Administration of Enrollment Process

☐ State staff conducts the enrollment process.

☒ The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

☒ The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Aging and Disability Resource Centers

Please list the functions that the contractor will perform:

- [x] choice counseling
- [x] enrollment
- [x] other

Please describe:

The ADRC and county economic support unit each participate in the enrollment process. The ADRC has primary responsibility for developing an access plan for the local service area, which identifies the specific procedures these entities will follow to ensure timely and appropriate access to the Family Care benefit. In general terms, the roles of the entities are as follows:

ADRCs provide public information and education, outreach, information and assistance, benefit specialist services, long-term care options counseling and referral to appropriate LTC programs or providers, Family Care functional eligibility determination and level of care assessment using the State-developed automated long-term care functional screening tool, and coordination of the Family Care eligibility and enrollment processes. ADRCs provide unbiased enrollment consultation and information to anyone considering enrollment in Family Care so that they can make informed enrollment choices.

Income maintenance agencies determine financial eligibility for Medicaid and Family Care using the State-developed automated CARES system, and process enrollments into Family Care.

- [ ] State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries.

Please describe the process:

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (4 of 6)

2. Details (Continued)

c. Enrollment . The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

- [ ] This is a new program.

Please describe the implementation schedule (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

- [x] This is an existing program that will be expanded during the renewal period.

Please describe: Please describe the implementation schedule (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

See Implementation Schedule in Section A Part I D.2.d.

- [ ] If a potential enrollee does not select an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be auto-assigned or default assigned to a plan.

☐ Potential enrollees will have ○ day(s) / ○ month(s) to choose a plan.

ii. ☐ There is an auto-assignment process or algorithm.

In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs:

☐ The State automatically enrolls beneficiaries.

- ☐ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3).
- ☐ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1).
- ☐ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause.

Please specify geographic areas where this occurs:

☐ The State provides guaranteed eligibility of months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

☐ The State allows otherwise mandated beneficiaries to request exemption from enrollment in an MCO/PIHP/PAHP/PCCM.

Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

☐ The State automatically re-enrolls a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (5 of 6)

2. Details (Continued)

d. Disenrollment

☒ The State allows enrollees to disenroll from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

i. ☒ Enrollee submits request to State.

ii. ☒ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.

iii. ☐ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

☐ The State does not permit disenrollment from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

☐ The State has a lock-in period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of [ ] months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c).

Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee's health care needs):

x ☐ The State does not have a lock-in, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

x ☐ The State permits MCOs/PIHPs/PAHPs and PCCMs to request disenrollment of enrollees.

i. x ☐ MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee.

Please describe the reasons for which enrollees can request reassignment

The PIHP can request reassignment of an enrollee for the following reasons: member refusal to participate in care planning or refusal to allow care management contacts.

If a PIHP initiated request for disenrollment is approved by the Department, the Department's contract coordinator assigned to the PIHP sets the disenrollment date and notifies the county income maintenance agency to process the disenrollment in CARES. The process includes automatic generation of a written notice to the person disenrolled. A disenrollment date due to inability to assure health and safety is set according to adverse action logic built into CARES. A disenrollment date due to member acts that pose a threat to health and safety are established and processed immediately according to the date set by the Department. (Note: To date, there have been no PIHP-initiated disenrollments approved by the State due to inability to assure health and safety or due to member acts that pose a threat to health and safety.)

ii. x ☐ The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

iii. ☐ If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

iv. x ☐ The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

Section A: Program Description

Part IV: Program Operations

C. Enrollment and Disenrollment (6 of 6)

Additional Information. Please enter any additional information not included in previous pages:
Disenrollments are managed through the ADRC using a consistent state-approved process. The PIHP can assist the member in starting this process as well. People are permitted to move freely between long term support programs; therefore, requests are approved.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (1 of 2)

1. Assurances

- [x] The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
- [ ] The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

  Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

- [x] The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- [ ] This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- [x] The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

Section A: Program Description

Part IV: Program Operations

D. Enrollee Rights (2 of 2)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (1 of 5)

1. Assurances for All Programs States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including:

   a. informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,
   b. ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and
   c. other requirements for fair hearings found in 42 CFR 431, Subpart E.

- [x] The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (2 of 5)

2. Assurances For MCO or PIHP programs. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

   [x] The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

   Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

   [x] The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

E. Grievance System (3 of 5)

3. Details for MCO or PIHP programs

   a. Direct Access to Fair Hearing

   [ ] The State requires enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

   [x] The State does not require enrollees to exhaust the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

   b. Timeframes

   [x] The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an appeal is 45 days (between 20 and 90).

   [x] The State's timeframe within which an enrollee must file a grievance is 45 days.

   c. Special Needs

   [ ] The State has special processes in place for persons with special needs.

   Please describe:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (4 of 5)

4. Optional grievance systems for PCCM and PAHP programs. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

☐ The State has a grievance procedure for its ☐ PCCM and/or ☐ PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

The grievance procedures are operated by:

- ☐ the State
- ☐ the State's contractor.

  Please identify:
- ☐ the PCCM
- ☐ the PAHP

☐ Requests for review can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals):

Please describe:

☐ Has a committee or staff who review and resolve requests for review.

Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function:

☐ Specifies a time frame from the date of action for the enrollee to file a request for review.

Please specify the time frame for each type of request for review:

☐ Has time frames for resolving requests for review.

Specify the time period set for each type of request for review:

☐ Establishes and maintains an expedited review process.

Please explain the reasons for the process and specify the time frame set by the State for this process:

☐ Permits enrollees to appear before State PCCM/PAHP personnel responsible for resolving the request for review.

☐ Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

☐ Other.

Please explain:

Section A: Program Description

Part IV: Program Operations

E. Grievance System (5 of 5)

Additional Information. Please enter any additional information not included in previous pages:

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (1 of 3)

1. Assurances

[X] The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:

1. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
2. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

The prohibited relationships are:

1. A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
2. A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
3. A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

[X] The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:

1. could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
2. has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
3. employs or contracts directly or indirectly with an individual or entity that is
   a. excluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
   b. could be exclude under 1128(b)(8) as being controlled by a sanctioned individual.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (2 of 3)

2. Assurances For MCO or PIHP programs

[X] The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.

[X] State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

☐ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of the regulatory requirements listed for PIHP or PAHP programs.

Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any:

☒ The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section A: Program Description

Part IV: Program Operations

F. Program Integrity (3 of 3)

Additional Information. Please enter any additional information not included in previous pages:

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (1 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- MCO, PIHP, and PAHP programs:
  - There must be at least one checkmark in each column.
- PCCM and FFS selective contracting programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Program Impact

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS	☐ FFS
Consumer Self-Report data	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO	☐ MCO

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Program Impact						
Monitoring Activity	Choice	Marketing	Enroll Disenroll	Program Integrity	Information to Beneficiaries	Grievance
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (2 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- MCO, PIHP, and PAHP programs:
  - There must be at least one checkmark in each column.
- PCCM and FFS selective contracting programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Access

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP	☐ MCO ☐ PIHP ☐ PAHP

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS	☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO	☐ MCO	☐ MCO

Evaluation of Access			
Monitoring Activity	Timely Access	PCP / Specialist Capacity	Coordination / Continuity
	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part I: Summary Chart of Monitoring Activities

Summary of Monitoring Activities (3 of 3)

The charts in this section summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a "big picture" of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- MCO, PIHP, and PAHP programs:
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- PCCM and FFS selective contracting programs:
  - There must be at least one checkmark in each column under "Evaluation of Program Impact."
  - There must be at least one check mark in one of the three columns under "Evaluation of Access."
  - There must be at least one check mark in one of the three columns under "Evaluation of Quality."

Summary of Monitoring Activities: Evaluation of Quality

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Qualitiy of Care
Accreditation for Non-duplication	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Accreditation for Participation	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Consumer Self-Report data	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Data Analysis (non-claims)	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Enrollee Hotlines	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Focused Studies	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Qualitiy of Care
	☐ FFS	☐ FFS	☐ FFS
Geographic mapping	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Independent Assessment	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Measure any Disparities by Racial or Ethnic Groups	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Network Adequacy Assurance by Plan	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Ombudsman	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
On-Site Review	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Improvement Projects	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Performance Measures	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Periodic Comparison of # of Providers	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP	☐ MCO ☐ PIHP

Evaluation of Quality			
Monitoring Activity	Coverage / Authorization	Provider Selection	Qualitiy of Care
	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS	☐ PAHP ☐ PCCM ☐ FFS
Profile Utilization by Provider Caseload	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Provider Self-Report Data	☐ MCO ☒ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Test 24/7 PCP Availability	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Utilization Review	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS
Other	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS	☐ MCO ☐ PIHP ☐ PAHP ☐ PCCM ☐ FFS

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Details of Monitoring Activities by Authorized Programs

For each program authorized by this waiver, please provide the details of its monitoring activities by editing each program listed below.

Programs Authorized by this Waiver:

Program	Type of Program
Family Care	PIHP;

Note: If no programs appear in this list, please define the programs authorized by this waiver on the

Section B: Monitoring Plan

Part II: Details of Monitoring Activities

Program Instance: Family Care

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.
For each activity, the state must provide the following information:

- Personnel responsible (e.g. state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

a. ☐ Accreditation for Non-duplication (i.e. if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

Activity Details:

☐ NCQA
☐ JCAHO
☐ AAAHC
☐ Other

Please describe:

b. ☐ Accreditation for Participation (i.e. as prerequisite to be Medicaid plan)

Activity Details:

☐ NCQA
☐ JCAHO
☐ AAAHC
☐ Other

Please describe:

c. ☒ Consumer Self-Report data

Activity Details:
Responsible entity: State
Activity: State develops enrollee satisfaction survey tool; instructs PIHPs in methods to administer the survey; State collects and analyzes data
Frequency: Annual
Information: The tool is designed to solicit enrollee feedback about the PIHPs performance in offering choice, coverage, authorization, provider selection and quality of care

☐ CAHPS

Please identify which one(s):

☒ State-developed survey
☐ Disenrollment survey
☐ Consumer/beneficiary focus group

d. ☒ Data Analysis (non-claims)

Activity Details:
Responsible entity: State
Activity: PIHPs report data from local grievances and appeals and the State collects data

related to State-level appeals directed to the SMA and to the State Division of Hearings and Appeals; data is analyzed by State-staff oversight teams for each PIHP and by contract compliance staff.
Frequency: Data for individual PIHPs is analyzed quarterly by oversight teams; statewide data is reviewed quarterly by contract compliance staff.
Information: Data provides information on trends in grievances and appeals in individual PIHPs and collectively.

- [ ] Denials of referral requests
- [ ] Disenrollment requests by enrollee
  - [ ] From plan
  - [ ] From PCP within plan
- [X] Grievances and appeals data
- [ ] Other

Please describe:

e. [X] Enrollee Hotlines

Activity Details:
Responsible entity: State
Activity: State provides a toll free number for members to lodge appeals or grievances to the SMA.
Frequency: Ongoing
Information: The entity contracted to monitor the hotline provides summary data to the SMA about appeals and grievances reported on the hotline.

f. [ ] Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service)

Activity Details:

g. [ ] Geographic mapping

Activity Details:

h. [ ] Independent Assessment (Required for first two waiver periods)

Activity Details:

i. [ ] Measure any Disparities by Racial or Ethnic Groups

Activity Details:

j. [X] Network Adequacy Assurance by Plan [Required for MCO/PIHP/PAHP]

Activity Details:
Responsible entity: State
Activity: Certification of adequacy of PIHP network
Frequency: Annual
Information: PIHPs submit information about all providers in the PIHP network

k. [X] Ombudsman

Activity Details:
Responsible entity: Contracted ombudsman programs
Activity: Monitor PIHP performance in relation to grievances and appeals and information to beneficiaries
Frequency: Ongoing
Information: Ombudsman programs produce monthly and quarterly reports analyzed by State program management staff

l. [X] On-Site Review

Activity Details:
Responsible entity: State and EQRO
Activity: Quality reviews
Frequency: Annual
Information: The tools used in the reviews are designed to collect information about choice, marketing, enroll/disenroll, program integrity, information to beneficiaries, grievance, timely access, capacity, coordination/continuity, coverage/authorization and quality of care.

m. [X] Performance Improvement Projects [Required for MCO/PIHP]

Activity Details:
Responsible entity: PIHP
Activity: All PIHPs must identify and conduct one PIP per year. The PIP may be clinical or nonclinical as determined applicable to the member quality improvement needs assessed by each PHIP. The State maintains discretion to require up to two PIPs per year.
Frequency: Annual
Information: PIP activities and results are analyzed by the State and EQRO

- [X] Clinical
- [X] Non-clinical

n. [X] Performance Measures [Required for MCO/PIHP]

Activity Details:
Responsible entity: State and EQRO
Activity: Care management review, quality compliance review and annual certification (please see http://www.dhs.wisconsin.gov/ltcare/StateFedReqs/EQRO.htm)
Frequency: Annual
Information: The tools used in the reviews are designed to collect information about choice, marketing, enroll/disenroll, program integrity, information to beneficiaries, grievance, timely access, capacity, coordination/continuity, coverage/authorization and quality of care.

- [X] Process
- [X] Health status/ outcomes
- [X] Access/ availability of care
- [X] Use of services/ utilization
- [X] Health plan stability/ financial/ cost of care
- [X] Health plan/ provider characteristics
- [X] Beneficiary characteristics

o. [ ] Periodic Comparison of # of Providers

Activity Details:

p. [ ] Profile Utilization by Provider Caseload (looking for outliers)

Activity Details:

q. [ ] Provider Self-Report Data

Activity Details:

Survey of providers

Focus groups

r. Test 24/7 PCP Availability

Activity Details:

s. Utilization Review (e.g. ER, non-authorized specialist requests)

Activity Details:

t. Other

Activity Details:

Section C: Monitoring Results

Renewal Waiver Request

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is a renewal request.

- (●) This is the first time the State is using this waiver format to renew an existing waiver.The State provides below the results of the monitoring activities conducted during the previous waiver period.
- ( ) The State has used this format previouslyThe State provides below the results of the monitoring activities conducted during the previous waiver period.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- Confirm it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- Summarize the results or findings of each activity. CMS may request detailed results as appropriate.
- Identify problems found, if any.
- Describe plan/provider-level corrective action, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- Describe system-level program changes, if any, made as a result of monitoring findings.

The Monitoring Activities were conducted as described:

◉ Yes ○ No

If No, please explain:

Provide the results of the monitoring activities:

Consumer Self-Report Data - PIHPs are required to participate in a program-wide member survey. All PIHPs must include a set of common questions in their survey. The SMA compiles the survey results. Generally, levels of positive experience with Family Care PIHPs are high. Responses of "Always" to survey questions are at least 65% and when the "Most of the Time" response is added, all but one question has a 90% or higher positive response. The statement, "I participate in making decisions about the services I receive" had an "Always" response of 65% and a combined "Always and "Most of the Time" response of 89%. While this is an increase from previously reported results of 63% and 88%, it is an indicator that the SMA would like to see improve over the coming years.

Grievances and Appeals - Grievance and appeal numbers are small-both at the local and State level. State appeals to the SMA and the State Division of Hearings and Appeals (member access to DHA appeals is required by State statute) had a monthly average of 1 per 1000 enrollees. Members are informed of their right to appeal to DHA and are able to file that appeal concurrently with other levels of appeal. State data does not show any problematic trends and the SMA did not identify any trends or issues with local grievances and appeals reported by PIHPs.

Focused Studies – Medication Management - The SMA conducted a pilot to assess the need for automated medication dispensing devices. Over the course of the pilot (April through December 2013), over 24,000 members were screened for risk related to adherence to their medication regimen upon enrollment, during a regular review or following an event such as a change in condition. Almost 21,000 of the assessed members were determined to have some risk and, of those, 285 received a medication management device. Over half already had an intervention in place that was working or were scheduled to have an intervention added to their plan. Another 7,000 were determined not to have adherence issues although they were assessed with risk. The pilot revealed that many members were receiving assistance with medication adherence and that the devices were not the most appropriate intervention for them. PIHPs continue to assess members for medication adherence risk.

Network Adequacy Assurance by Plan - DHS annually reviews the adequacy of each PIHP's network. PIHPs are required to have current (no older than 45 days) provider information available on their website. PIHP networks are assessed for adequacy of the overall range of providers to deliver the services in the Family Care benefit package and to ensure there are a sufficient number, mix, and geographic distribution of providers to meet the needs of the anticipated number of enrollees in the service area. No significant issues were identified between 2012 and 2014. A few PIHPs appeared to lack a sufficient number of providers in certain parts of their geographic service area. The SMA oversight team monitored the PIHPs efforts to fill that gap and the PIHPs added additional providers. This issue is resolved and there are no outstanding issues.

On-Site Review - The EQRO conducts an on-site Annual Quality Review (AQR) of each PIHP. The AQR assesses the following PIHP systems and processes: Care Management Review, Assessment, Planning, Service Coordination and Delivery, Participant Centered Focus, Validation of Performance Improvement Projects, Quality Compliance Review, Enrollee Rights, Access to Services, Structure and Operations, Quality Measurement and Improvement, and Grievance Systems. The AQR results are submitted to the SMA and can be found at: http://www.dhs.wisconsin.gov/ltcare/StateFedReqs/eqro12-13.pdf. Various issues were identified for each PIHP. The SMA Oversight Team required correction actions, made improvement recommendations and monitored PIHP completion of requirements.

Performance Improvement Projects (PIPS)- See EQRO report at http://www.dhs.wisconsin.gov/ltcare/StateFedReqs/eqro12-13.pdf.

Performance Measures - See Care Management Review and Quality Compliance Review in the EQRO report at http://www.dhs.wisconsin.gov/LTCare/StateFedReqs/eqro09-10/annualrpt.pdf.

Provider Self-Report Data - PIHPs annually submit assurances that they do not knowingly employ or contract with excluded individuals or entities, and that they have written policies and procedures to guard against fraud and abuse. PIHPs check the excluded provider registry upon initial contract with a provider.

Periodic Care Plan Reviews - See Care Management Review in the EQRO report at: http://www.dhs.wisconsin.gov/LTCare/StateFedReqs/eqro09-10/annualrpt.pdf.

Various issues were identified and recommendations made for PIHPs to improve their implementation of PIPs. The most commonly occurring areas where PIHPs struggled were providing notice of action in a timely manner and consistently offering self-directed supports options to members. PIHPs chose to implement PIPs to improve these issues that were identified during periodic care plan reviews. The SMA Oversight Team required correction actions, made improvement recommendations and monitored PIHP completion of requirements. The SMA has also developed and implemented additional standardized notice of action forms and instructions for their use.

Aging and Disability Resource Center - ADRCs provide information to enrollees and potential enrollees about the Family Care benefit, PIHPs and other options available. ADRCs provide outreach and marketing for the Family Care program and monitor marketing by PIHPs or their providers which is not allowed. They also provide options counseling to persons who choose to disenroll from Family Care. The SMA has not received any reports of inappropriate marketing activities by a PIHP.

Section D: Cost-Effectiveness

Medical Eligibility Groups

Title	
Nursing Home Level of Care	
Non-Nursing Home Level of Care	

	First Period		Second Period	
	Start Date	End Date	Start Date	End Date
Actual Enrollment for the Time Period**	10/01/2012	09/30/2013	10/01/2013	09/30/2014
Enrollment Projections for the Time Period*	01/01/2015	12/31/2015	01/01/2016	12/31/2016

**Include actual data and dates used in conversion - no estimates
*Projections start on Quarter and include data for requested waiver period

Section D: Cost-Effectiveness

Services Included in the Waiver

Document the services included in the waiver cost-effectiveness analysis:

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Adaptive Aids - General			X	
Adaptive Aids - Vehicles			X	
Adult Day Care			X	
Alcohol and Drug Abuse Day Treatment	X		X	
AODA Treatment (excludes those provided by a physician or on an inpatient basis)	X		X	
Case Management	X		X	
Communication Aids/Assistive Technologies			X	
Community Support Program	X		X	
Consultative Clinical and Therapeutic Services for Caregivers			X	
Consumer Directed Supports (Self Directed Supports) Support Broker			X	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Consumer Education and Training			X	
Counseling/Therapeutic Resources			X	
Daily Living Skills Training			X	
Day Habilitation Services			X	
Disposable Medical Supplies	X		X	
Durable Medical Equipment (excluding hearing aids and prosthetics)	X		X	
Financial Management Services			X	
Home Health Services	X		X	
Home Modifications	X		X	
Housing Counseling			X	
Meals - Home Delivered			X	
Mental Health Counseling/Therapy (except those provided by a physician or on an inpatient basis)	X		X	
Mental Health Day Treatment	X		X	
Nursing Home Stays (Nursing Home, Institution for Mental Disease (IMD) and ICF-I/ID Facility)	X		X	
Occupational Therapy	X		X	
Personal Care	X		X	
Personal Emergency Response System Services			X	
Physical Therapy	X		X	
Prevocational Services			X	
Relocation Services			X	
Residential Services - RCAC, CBRF, Adult Family Home			X	
Respiratory Therapy by Independent Nurse or Therapist Employed by a Home Health Agency	X		X	
Respite Care			X	
Self-Directed Personal Care			X	
Skilled Nursing	X		X	
Specialized Medical Supplies			X	
Speech and Language Pathology Services (except in inpatient hospital settings)	X		X	
Supported Employment - Individual Employment Support			X	
Supported Employment - Small Group Employment Support			X	
Supportive Home Care			X	
Training Services for Unpaid Caregivers			X	

Service Name	State Plan Service	1915(b)(3) Service	Included in Actual Waiver Cost	
Transportation - Common Carrier	X		X	
Transportation - Community - Non-medical			X	
Transportation - Community - Self-directed non-emergency medical			X	
Transportation - Medical (including specialized medical vehicle)	X		X	
Vocational Futures Planning and Support			X	

Section D: Cost-Effectiveness

Part I: State Completion Section

A. Assurances

a. [Required] Through the submission of this waiver, the State assures CMS:

- The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
- The State assures CMS that the actual waiver costs will be less than or equal to or the State's waiver cost projection.
- Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
- Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
- The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
- The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State's submitted CMS-64 forms.

Signature:

State Medicaid Director or Designee

Submission Date:

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

b. Name of Medicaid Financial Officer making these assurances:

Amy McDowell

c. Telephone Number:

(608) 266-2708

d. E-mail:

Amy.McDowell@dhs.wisconsin.gov

e. The State is choosing to report waiver expenditures based on

- (●) date of payment.
- ( ) date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

Section D: Cost-Effectiveness

Part I: State Completion Section

B. Expedited or Comprehensive Test

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.

b. ☐ The State provides additional services under 1915(b)(3) authority.
c. ☐ The State makes enhanced payments to contractors or providers.
d. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver.
e. ☐ The State uses a sole-source procurement process to procure State Plan services under this waiver. Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete Appendix D3
- Your waiver will not be reviewed by OMB at the discretion of CMS and OMB.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

Section D: Cost-Effectiveness

Part I: State Completion Section

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in A.I.b.

a. ☐ MCO
b. ☒ PIHP
c. ☐ PAHP
d. ☐ PCCM
e. ☐ Other

Please describe:

Section D: Cost-Effectiveness

Part I: State Completion Section

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

a. ☐ Management fees are expected to be paid under this waiver.

The management fees were calculated as follows.

1. ☐ Year 1: $ [ ] per member per month fee.
2. ☐ Year 2: $ [ ] per member per month fee.
3. ☐ Year 3: $ [ ] per member per month fee.
4. ☐ Year 4: $ [ ] per member per month fee.

b. ☐ Enhanced fee for primary care services.

Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.

c. ☐ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under D.I.H.d., please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost.

d. ☐ Other reimbursement method/amount.

$ [ ]

Please explain the State's rationale for determining this method or amount.

[ ]

Section D: Cost-Effectiveness

Part I: State Completion Section

E. Member Months

Please mark all that apply.

a. ☒ [Required] Population in the base year and R1 and R2 data is the population under the waiver.

b. ☐ For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.

c. ☒ [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:

Member months are expected to increase in existing Family Care counties due to growth that has historically been experienced in counties after Family Care becomes an entitlement. Additional program growth is expected beginning in P1 (CY2015), and continuing through the waiver period, when seven counties are expected to begin operating the Family Care program. Further growth is expected in P2 (CY2016) when Rock county begins to operate the Family Care program. Adams, Florence, Forest, Oneida, Taylor, and Vilas counties in are assumed to begin operating the Family Care program during P3 (CY2017). Finally, Dane county is assumed to begin operating the Family Care program in P4 (CY2018). Program expansion is reflected in the Implementation Plan in Section A Part I D.2.

The member month projections are based on PIHP business plans, historical trends in Family Care enrollment, and county-specific populations. Approximately 6,600 home and community based-waiver enrollees and 2,100 persons on the waiting list for long-term care services are expected to gradually transition into Family Care. The transition periods for counties with existing home and community-based waivers range from one to seven months. Persons on a waitlist are assumed to be enrolled evenly over 36 months. Roughly 67% of people are assumed to enroll in the Family Care program with the other 33% enrolling in the Self-Directed 1915(c) waiver option. When the program becomes an entitlement in a county beginning in month 37 after program operations begin, historical enrollment shows annual growth rates of approximately 12% in a county's first year of entitlement, 11% in the second, 9% in the third, and 2%

thereafter.

Family Care member months are expected to increase by 5.2% from R2 to P1, 5.9% from P1 to P2, 4.1% from P2 to P3, 6.1% from P3 to P4, and 3.0% from P4 to P5.

The transition period assumptions above are preliminary and are intended to be used for budgeting purposes only. Actual transition periods will be determined upon consultation with PIHPs, counties, ADRCs, and other interested parties after PIHP contracts have been awarded.

d. [x] [Required] Explain any other variance in eligible member months from BY/R1 to P2:

The majority the growth in member months beginning in P1 (CY2015) is attributable to the gradual enrollment of persons on the waitlist and transitioning home and community based-waiver enrollees into Family Care as described above. Additional growth is expected in counties that have reached entitlement based on historical experience.

Total enrollment in R1 was less than projected in the current approved waiver due mainly to changes in the implementation schedule that was assumed in the previous waiver. At the same time, the State exceeded the projected Non-Nursing Home Level of Care Medicaid Eligibility Group (MEG) member months in R1 (CY2013). The proportion of new members enrolling in the Non-Nursing Home Level of Care was slightly underestimated in the R1 (CY2013) projections due to using historical data weighted heavily on experience during the transition to Family Care. The P1 (CY2015) – P5 (CY2019) enrollment projections for existing counties are based on more recent data which more closely reflects Non-Nursing Home Level of Care enrollment proportions of established Family Care counties.

e. [x] [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:

Per CMS request, R1 is 10/1/2012 - 9/30/2013. R2 is 10/1/2013 – 9/30/2014.

Appendix D1 – Member Months

Section D: Cost-Effectiveness

Part I: State Completion Section

F. Appendix D2.S - Services in Actual Waiver Cost

For Conversion or Renewal Waivers:

a. [x] [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in Appendix D3 than for the upcoming waiver period in Appendix D5.
Explain the differences here and how the adjustments were made on Appendix D5:

Consultative Clinical and Therapeutic Services for Caregivers and Training Services for Unpaid Caregivers were added as new home and community-based benefits 1/1/2015, which added $0.54 PMPM on average to the capitation rates for the Nursing Home level of care. Adjustments to reflect the costs of these new benefits are included with other policy adjustments in Appendix D5.

Supported Employment was split into Individual Employment Support and Small Group Employment Support categories; however, this does not affect costs. This change was made based on the September 16, 2011 CMCS Informational Bulletin updating the 1915(c) Waiver Instructions and Technical guide regarding employment and employment related services. In this guidance supported employment was changed into two separate 1915(c) Waiver services, Supported employment -small group employment and Supported employment -individual employment.

State plan services previously listed in this section unrelated to the waiver were removed to align with CMS instructions and technical guidance.

b. [x] [Required] Explain the exclusion of any services from the cost-effectiveness analysis.

For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

Primary and acute health care are carved out of the Family Care benefit.

Appendix D2.S: Services in Waiver Cost

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
Adaptive Aids - General	☐	☐	☐	X	☐	☐	☐
Adaptive Aids - Vehicles	☐	☐	☐	X	☐	☐	☐
Adult Day Care	☐	☐	☐	X	☐	☐	☐
Alcohol and Drug Abuse Day Treatment	☐	☐	☐	X	☐	☐	☐
AODA Treatment (excludes those provided by a physician or on an inpatient basis)	☐	☐	☐	X	☐	☐	☐
Case Management	☐	☐	☐	X	☐	☐	☐
Communication Aids/Assistive Technologies	☐	☐	☐	X	☐	☐	☐
Community Support Program	☐	☐	☐	X	☐	☐	☐
Consultative Clinical and Therapeutic Services for Caregivers	☐	☐	☐	X	☐	☐	☐
Consumer Directed Supports (Self Directed Supports) Support Broker	☐	☐	☐	X	☐	☐	☐
Consumer Education and Training	☐	☐	☐	X	☐	☐	☐
Counseling/Therapeutic Resources	☐	☐	☐	X	☐	☐	☐
Daily Living Skills Training	☐	☐	☐	X	☐	☐	☐
Day Habilitation Services	☐	☐	☐	X	☐	☐	☐
Disposable Medical Supplies	☐	☐	☐	X	☐	☐	☐
Durable Medical Equipment (excluding hearing aids and prosthetics)	☐	☐	☐	X	☐	☐	☐
Financial Management Services	☐	☐	☐	X	☐	☐	☐
Home Health Services	☐	☐	☐	X	☐	☐	☐
Home Modifications	☐	☐	☐	X	☐	☐	☐
Housing Counseling	☐	☐	☐	X	☐	☐	☐
Meals - Home Delivered	☐	☐	☐	X	☐	☐	☐
Mental Health Counseling/Therapy (except those provided	☐	☐	☐	X	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
by a physician or on an inpatient basis)							
Mental Health Day Treatment	☐	☐	☐	X	☐	☐	☐
Nursing Home Stays (Nursing Home, Institution for Mental Disease (IMD) and ICF-I/ID Facility)	☐	☐	☐	X	☐	☐	☐
Occupational Therapy	☐	☐	☐	X	☐	☐	☐
Personal Care	☐	☐	☐	X	☐	☐	☐
Personal Emergency Response System Services	☐	☐	☐	X	☐	☐	☐
Physical Therapy	☐	☐	☐	X	☐	☐	☐
Prevocational Services	☐	☐	☐	X	☐	☐	☐
Relocation Services	☐	☐	☐	X	☐	☐	☐
Residential Services - RCAC, CBRF, Adult Family Home	☐	☐	☐	X	☐	☐	☐
Respiratory Therapy by Independent Nurse or Therapist Employed by a Home Health Agency	☐	☐	☐	X	☐	☐	☐
Respite Care	☐	☐	☐	X	☐	☐	☐
Self-Directed Personal Care	☐	☐	☐	X	☐	☐	☐
Skilled Nursing	☐	☐	☐	X	☐	☐	☐
Specialized Medical Supplies	☐	☐	☐	X	☐	☐	☐
Speech and Language Pathology Services (except in inpatient hospital settings)	☐	☐	☐	X	☐	☐	☐
Supported Employment - Individual Employment Support	☐	☐	☐	X	☐	☐	☐
Supported Employment - Small Group Employment Support	☐	☐	☐	X	☐	☐	☐
Supportive Home Care	☐	☐	☐	X	☐	☐	☐
Training Services for Unpaid Caregivers	☐	☐	☐	X	☐	☐	☐
Transportation - Common Carrier	☐	☐	☐	X	☐	☐	☐
Transportation - Community - Non-medical	☐	☐	☐	X	☐	☐	☐
Transportation - Community - Self-	☐	☐	☐	X	☐	☐	☐

State Plan Services	MCO Capitated Reimbursement	FFS Reimbursement impacted by MCO	PCCM FFS Reimbursement	PIHP Capitated Reimbursement	FFS Reimbursement impacted by PIHP	PAHP Capitated Reimbursement	FFS Reimbursement impacted by PAHP
directed non-emergency medical							
Transportation - Medical (including specialized medical vehicle)	☐	☐	☐	☒	☐	☐	☐
Vocational Futures Planning and Support	☐	☐	☐	☒	☐	☐	☐

Section D: Cost-Effectiveness

Part I: State Completion Section

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.
The allocation method for either initial or renewal waivers is explained below:

a. ☐ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrolleesNote: this is appropriate for MCO/PCCM programs.
b. ☒ The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled.Note: this is appropriate for statewide PIHP/PAHP programs.
c. ☐ Other
Please explain:

Appendix D2.A: Administration in Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

H. Appendix D3 - Actual Waiver Cost

a. ☐ The State is requesting a 1915(b)(3) waiver in Section A.I.A.1.c and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.
b. ☒ The State is including voluntary populations in the waiver.
Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

The issue of selection bias is handled through the State's risk adjustment process. Risk adjustment has been a central component of Family Care rate setting from the program's inception. Historical costs of actual program enrollees are used as the base cost for the capitation rates. Functional status information obtained from the long-term care functional screen tool is then used to risk adjust the capitation rates. The PIHPs are paid a capitation that reflects case mix across 35 - 67 different measures of functional status. The detail behind this risk adjustment approach is contained in each year's rate report from the State's contracted actuaries at PricewaterhouseCoopers (PwC).
c. ☒ Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the

MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.
Basis and Method:

1. ☐ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. ☒ The State provides stop/loss protection

   Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

   Stop loss is met by the State requiring working capital, restricted reserves, and pooled solvency fund contributions by each PIHP.

d. ☒ Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. ☒ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (Column D of Appendix D3 Actual Waiver Cost). Regular State Plan service capitated adjustments would apply.

   Document

   i. Document the criteria for awarding the incentive payments.
   ii. Document the method for calculating incentives/bonuses, and
   iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

   i. The Department will provide an incentive payment to the PIHP of $1,000 for each member of a PIHP who is relocated from an institution into a community setting consistent with federal Money Follows the Person (MFP) guidelines.

   The incentive is a one time payment paid to the PIHP per relocated member. The incentive payments themselves are not incorporated into rate setting for future years, but the service costs for the member are included in the encounter data used for future year rate setting.

   ii. The amount of payment provided to a PIHP will be determined after the end of the contract year. The PIHP will submit before December 31 of the contract year a list of members for whom the PIHP anticipates a receipt of an incentive payment. The Department will compare the PIHP's list of member's to the Department's list of Medicaid members for whom the Department is receiving an enhanced Medicaid match through the MFP program to determine the number of relocations to use for calculation the incentive payment to the PIHP. The Department will notify the PIHP of the estimated amount of the incentive payment and the list of PIHP members for whom an incentive payment is being made prior to issuing the incentive payment.

   iii. The approximate amount of anticipated incentive payment will be known prior to the end of the contract year. As described in the method above, the PIHP will submit before December 31 of the contract year a list of members for whom the PIHP anticipates a receipt of an incentive payment. The Department will compare the PIHP's list of member's to the Department's list of Medicaid members for whom the Department is receiving an enhanced Medicaid match through the MFP program.

2. ☐ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (Column G of Appendix D3 Actual Waiver Cost).). For PCCM providers, the amount listed should match information provided in D.I.D Reimbursement of Providers. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (See D.I.I.e and D.I.J.e)

   Document:

i. Document the criteria for awarding the incentive payments.
ii. Document the method for calculating incentives/bonuses, and
iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Appendix D3 – Actual Waiver Cost

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (1 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (2 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (3 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (4 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (5 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (6 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (7 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

I. Appendix D4 - Adjustments in the Projection OR Conversion Waiver for DOS within DOP (8 of 8)

This section is only applicable to Initial waivers

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (1 of 5)

a. State Plan Services Trend Adjustment – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. . This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.

1. [X] [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (i.e., trending from 1999 to present).

   The actual trend rate used is: 3.41

   Please document how that trend was calculated:

   Nursing Home Level of Care: 3.4%

   Non-Nursing Home Level of Care: 3.4%

   Trend rates are based primarily on the trends calculated by the State's contracted actuary, PricewaterhouseCoopers, for CY 2015 capitation rate development. The trend estimates were developed for Developmentally Disabled, Physically Disabled, and Frail Elder target groups for both Medicaid Eligibility Groups combined using standard actuarial practices based on actual CY 2011 – CY 2013 cost data from existing Family Care counties.

   The individual target group trends are adjusted to reflect State budget assumptions. The State budget assumes cost increases of 2.25% in CY2015 over the aggregate service cost trend developed by the actuaries to arrive at the trend of 3.4% in CY2015. Analyses suggest that the service cost trends for the Family Care program as a whole have been held down in recent years due to an increasing proportion of new members enrolling at a lower acuity level relative to a decreasing proportion of existing higher cost

members that enrolled from the legacy waivers. As these proportions stabilize, overall cost increases will no longer be diluted by an increasing proportion of lower cost members. The trend in the State budget is, therefore, adjusted to reflect trends more consistent with the Consumer Price Index. Trends are weighted by target group enrollment to arrive at the composite trend for each MEG for each year.

2. ☐ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (i.e., trending from present into the future).

   i. ☒ State historical cost increases.

   Please indicate the years on which the rates are based: base years. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

   Years on which the rates are based: CY 2011 – CY 2013.

   Trend rates are based primarily on the trends calculated by the State's contracted actuary, PricewaterhouseCoopers, for CY 2015 capitation rate development. The trend estimates were developed for Developmentally Disabled, Physically Disabled, and Frail Elder target groups for both Medicaid Eligibility Groups combined using standard actuarial practices based on actual CY 2011 – CY 2013 cost data from existing Family Care counties.

   The individual target group trends are adjusted to reflect State budget assumptions. The State budget assumes cost increases of 2.25% in CY2015 and 1.75% in CY2016 - CY2019 over the aggregate service cost trend developed by the actuaries to arrive at the trends of 3.4% in CY2015 and 2.9% in CY2016 - CY2019. Analyses suggest that the service cost trends for the Family Care program as a whole have been held down in recent years due to an increasing proportion of new members enrolling at a lower acuity level relative to a decreasing proportion of existing higher cost members that enrolled from the legacy waivers. As these proportions stabilize, overall cost increases will no longer be diluted by an increasing proportion of lower cost members. The trend in the State budget is, therefore, adjusted to reflect trends more consistent with the Consumer Price Index. Trends are weighted by target group enrollment to arrive at the composite trend for each MEG for each year. Trends rates are as follows:

   Nursing Home Level of Care: 3.4% from R2 (CY 2014) to P1 (CY 2015), 2.9% from P1 (CY 2015) to P2 (CY 2016), 2.9 % from P2 (CY 2016) to P3 (CY 2017), 2.9% from P3 (CY 2017) to P4 (CY 2018), and 2.9% from P4 (CY 2018) to P5 (CY 2019).

   Non-Nursing Home Level of Care: 3.4% from R2 (CY 2014) to P1 (CY 2015), 2.9% from P1 (CY 2015) to P2 (CY 2016), 2.9 % from P2 (CY 2016) to P3 (CY 2017), 2.9% from P3 (CY 2017) to P4 (CY 2018), and 2.9% from P4 (CY 2018) to P5 (CY 2019).

   ii. ☐ National or regional factors that are predictive of this waiver's future costs.

   Please indicate the services and indicators used. In addition, please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

3. ☐ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase.

Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between R2 and P1 and between years P1 and P2.

   i. Please indicate the years on which the utilization rate was based (if calculated separately only).
   ii. Please document how the utilization did not duplicate separate cost increase trends.

Appendix D4 – Adjustments in Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (2 of 5)

b. State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend. If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA. The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee
- Graduate Medical Education (GME) Changes - This adjustment accounts for changes in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. ☐ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. ☒ An adjustment was necessary. The adjustment(s) is(are) listed and described below:
   i. ☐ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
   Please list the changes.

   For the list of changes above, please report the following:

   A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
   PMPM size of adjustment

   B. ☐ The size of the adjustment was based on pending SPA.
   Approximate PMPM size of adjustment

   C. ☐ Determine adjustment based on currently approved SPA.
   PMPM size of adjustment

D. ☐ Determine adjustment for Medicare Part D dual eligibles.

E. ☐ Other:

Please describe

ii. ☐ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.

iii. ☐ Changes brought about by legal action:

Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.

PMPM size of adjustment

D. ☐ Other

Please describe

iv. ☐ Changes in legislation.

Please list the changes.

For the list of changes above, please report the following:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).

PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.

Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA

PMPM size of adjustment

D. ☐ Other

Please describe

v. ☒ Other

Please describe:

A. ☐ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA).
PMPM size of adjustment

B. ☐ The size of the adjustment was based on pending SPA.
Approximate PMPM size of adjustment

C. ☐ Determine adjustment based on currently approved SPA.
PMPM size of adjustment

D. ☒ Other
Please describe
Program adjustments are included each year to compensate for payment timing differences in the CMS 64.9 reports, PIHP enrollment mix changes, capitation rate policy adjustments, implementation in new service areas, the addition of new services, and other lump sum payments. DUE TO SPACE LIMITATIONS IN THE WMS, PLEASE REFER TO THIS SECTION IN THE PRE-PRINT FOR A DETAILED DESCRIPTION.

The following program adjustments are included:

An adjustment of -0.13% was made to NH LOC and 0.11% to Non-NH LOC in P1 (CY2015) to reflect payments and recoveries reported in the CMS 64.9 for R1 and R2, but need to be excluded in projected future periods as these costs will not be incurred again in the projection period.

Enrollment changes in PIHPs serving existing Family Care counties affect the average program-wide capitation rates. This adjustment relates to the effect of PIHPs with different capitation rates having different enrollment growth rates. The aggregate capitation rate will increase if there is more enrollment growth MCOs with higher capitation rates and will decrease if enrollment is higher in MCOs with lower capitation rates. The impact of enrollment in counties implementing Family Care is described in a separate program adjustment. Adjustments to NH LOC are -0.47% in P1 (CY 2015), -0.18% in P2 (CY 2016), -0.31% in P3 (CY 2017), 0.08% in P4 (CY 2018), and -0.33% in P5 (CY 2019). Adjustments included in Non-NH LOC are -0.66% in P1 (CY 2015), -0.12% in P2 (CY 2016), -0.12% in P3 (CY 2017), -0.11% in P4 (CY 2018), and -0.11% in P5 (CY 2019).

An adjustment of 0.75% was needed to NH LOC for P1 (CY 2015) to compensate for a one time policy adjustment made to R2 (CY 2014) rates for one PIHP. The PIHP made changes to its operating structure that cut costs dramatically and would have resulted in excessive profits. Capitation rates were reduced for the year and PIHP was required to use the surplus to re-establish certain program operations that had been cut.

Family Care program expansion to additional counties requires NH LOC adjustments of 0.23% in P1 (CY 2015), 0.36% in P2 (CY 2016), -0.10% in P3 (CY 2017), 0.43% in P4 (CY 2018), and -0.20% in P5 (CY 2019). Expansion related adjustments for Non-NH LOC are 0.00% in P1 (CY 2015), 0.00% in P2 (CY 2016), 0.00% in P3 (CY 2017), 0.00% in P4 (CY 2018), and 0.00% in P5 (CY 2019). The adjustments are the result of the case mix of the population in new implementation areas being added to the existing rate structure. Members enrolling from the wait list typically have lower acuity which suppresses any rate increases that would otherwise occur. Rates in newly implemented counties include a phase-in adjustment during the first 24 months that a county is transitioning to Family Care. The incentive decreases by 50% in months 13-24 and is removed completely after month 24.

Consultative Clinical and Therapeutic Services for Caregivers and Training Services for Unpaid Caregivers will be added as new home and community-based benefits 1/1/2015 adding $0.54 PMPM to the NH LOC capitation rates. An adjustment of 0.02% is included in P1 (CY 2015).

Nursing home supplemental payments will not be made to PIHPs on or after 1/1/2015. The payments are included in the 9/30/2014 CMS 64 requiring a -0.16% adjustment to the NH LOC in CY2015. Historically, nursing home supplemental payments are authorized under s.49.45(6u), Wis Stats, in which the legislative intent regarding the purpose of the payments is made explicit at 49.45(6u)(am):

> *Notwithstanding sub. (6m), from the appropriations under s. 20.435 (4) (o), and (w), for reduction of operating deficits, as defined under the methodology used by the department in December 2000, incurred by a facility that is established under s. 49.70 (1) or that is owned and operated by a city, village, or town, and as payment to care management organizations, the department may not distribute to these facilities and to care management organizations more than $39,100,000 in each fiscal year, as determined by the department. The total amount that a county certifies under this subsection may not exceed 100% of otherwise-unreimbursed care.*

Payments for high cost relocations have not yet been made to the PIHPs and have, therefore, not yet been reported on the CMS 64 requiring an adjustment of 0.72% to the NH LOC in P1 (CY 2015). These payments will be reported on future CMS 64s when the payments are made or incorporated into the capitation rates. Once the payments are added to P1 of the projection, they are automatically included in the cost base for future years, so no other adjustments are needed.

Money Follows the Person incentive payments were reported in the 6/30/2014 CMS 64 and will continue to be made in the future. Therefore, no policy adjustment is needed in the projection.

Funding is included in P1 (CY 2015) for adjustments to CY2015 capitation rates for PIHPs experiencing disproportionately high costs relative to the capitation rate model. These are contingent expenditures to stabilize PIHPs experiencing financial distress. There have been three PIHPs that have discontinued operations since 2008 that required additional funding. Four PIHPs are likely to be placed on either heightened financial monitoring or financial corrective action by the end of CY2014. Detailed review has indicated that PIHPs' operations to be the primary source of the financial difficulties, not the soundness of the capitation rates. The PIHPs are required to identify and implement efficiencies to reflect the payment model and will continue under enhanced financial monitoring, which includes monthly financial reporting. Additional funding would be incorporated into capitation rates. Contract amendments would be executed if the rate adjustments occur after the initial contract for year is signed. These costs are not reflected in the CMS 64 reports through 6/30/2014 requiring a policy adjustment of 0.54% in P1 (CY 2015). This funding is discontinued in P2 (CY 2016) resulting in a downward adjustment to NH LOC of -0.53%.

Net program adjustments in the NH LOC MEG are 1.5% in P1, -0.4% in P2, -0.4% in P3, 0.5% in P4, and -0.5% in P5.

Net program adjustments in the Non-NH LOC MEG are -0.6% in P1, -0.1% in P2, -0.1% in P3, -0.1% in P4, and -0.1% in P5.

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (3 of 5)

c. Administrative Cost Adjustment: This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs;

as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program. If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

1. ☐ No adjustment was necessary and no change is anticipated.
2. ☒ An administrative adjustment was made.
   - i. ☐ Administrative functions will change in the period between the beginning of P1 and the end of P2.
     Please describe:
   - ii. ☒ Cost increases were accounted for.
     - A. ☐ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
     - B. ☐ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
     - C. ☐ State Historical State Administrative Inflation. THe actual trend rate used is PMPM size of adjustment

       Please describe:

D. [X] Other

Please describe:
Annual service cost trends of 3.4% in P1 (CY 2015) and 2.9% in P2 (CY 2016) through P5 (CY 2019) are used for both the Nursing Home and Non-Nursing Home levels of care. Family Care will become a greater proportion of overall Wisconsin Medicaid expenditures as the program grows, which will increase Family Care's share of administrative costs proportionately as capitation rates increase.

iii. [ ] [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate.
Please document both trend rates and indicate which trend rate was used.

A. Actual State Administration costs trended forward at the State historical administration trend rate.

Please indicate the years on which the rates are based: base years

In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate.
Please indicate the State Plan Service trend rate from Section D.I.J.a. above

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (4 of 5)

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in Section D.I.H.a above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. [ ] [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1]
The State is using the actual State historical trend to project past data to the current time period (i.e., trending from 1999 to present).
The actual documented trend is:

Please provide documentation.

2. [ ] [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (i.e., trending from present into the future), the State must use the lower of State historical 1915(b)(3) trend or State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.
i.

A. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years

2. Please provide documentation.

B. State Plan Service trend

Please indicate the State Plan Service trend rate from Section D.I.J.a. above

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked Section D.I.H.d , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.I.a
   3.4% in P1 (CY 2015) and 2.9% in P2 (CY 2016) through P5 (CY 2019)
2. List the Incentive trend rate by MEG if different from Section D.I.I.a
   Not applicable. The State Plan service trend is used.
3. Explain any differences:
   Money Follow the Person incentive payments are accounted for in capitation costs as required in H.d.1 above. Therefore the trend rate for services is used.

Section D: Cost-Effectiveness

Part I: State Completion Section

J. Appendix D4 - Conversion or Renewal Waiver Cost Projection and Adjustments. (5 of 5)

p. Other adjustments including but not limited to federal government changes.

-
  - If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
  - Once the State's FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
  -
    - Excess payments addressed through transition periods should not be included in the 1915(b) cost effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
    - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
  - Pharmacy Rebate Factor Adjustment (Conversion Waivers Only) *: Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

    Basis and Method:

    1. ☐ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total

Medicaid population which includes accounting for Part D dual eligibles. Please account for this adjustment in Appendix D5.

2. ☐ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS or Part D for the dual eligibles.
3. ☐ Other

Please describe:

1. ☐ No adjustment was made.
2. ☒ This adjustment was made. This adjustment must be mathematically accounted for in Appendix D5.
   Please describe
   DUE TO SPACE LIMITATIONS IN THE WMS, PLEASE REFER TO THIS SECTION IN THE PRE-PRINT FOR A DETAILED DESCRIPTION.

Detail of Adjustments for Amendment WI.0007.R06.01:

P2: The $9.30 PMPM decrease is the difference between the cost of mental health services for all of P2 (CY 2016) in the renewal and only inpatient mental health for half of P2 (CY 2016) in the amendment. Removing outpatient mental health services decreased benefit cost from $12.84 PMPM to $7.05 PMPM resulting in a $5.79 decrease. The remaining mental health benefit is assumed to be available beginning 7/1/2016 instead of 1/1/2016 in the original renewal. Only including the member months during the period in which the benefit is available further decreases the full $7.05 PMPM benefit cost by $3.51 PMPM when distributed over the full year.

The result is a 0.3% decrease in the Program Adjustment for the Nursing Home Level of Care MEG and a 1.6% decrease for the Non-Nursing Home Level of Care MEG. The Non-Nursing Home Level of Care MEG change appears larger as a percentage due to having a lower capitation rate.

P3: A formula error in the Nursing Home Level of Care MEG resulted in the inflation adjustment related to the new waiver services added in P1 (CY2015) being entered incorrectly as a program adjustment in P3 (CY2017). $0.01 PMPM was subtracted from the PMPM Effect of Program Adjustment column and added to the PMPM Effect of Inflation column. There is no effect on total cost for P3 (CY2017). Appendix D5 has been corrected in the Excel workbook.

The $9.30 PMPM decrease to PMPM State Plan Service Costs, PMPM Total Actual Waiver Costs, and PMPM State Plan Service Cost Projection are all carried over from the P2 (CY 2016) changes.

The $0.17 decrease to the PMPM Effect of Inflation Adjustment is the $5.79 PMPM benefit cost decrease from removing outpatient mental health benefits multiplied by the inflation factor of 2.9%.

The increase to the PMPM Effect of Program Adjustment adds the $3.51 PMPM deducted in P2 (CY 2016) when the new benefit was not available for the entire year. This brings the benefit cost back to $7.05 PMPM for the full year. The result is a 0.1% decrease in the Program Adjustment Retro Acuity & Other Payments column for the Nursing Home Level of Care MEG and a 0.6% decrease for the Non-Nursing Home Level of Care MEG. The Non-Nursing Home Level of Care MEG change appears larger as a percentage due to having a lower capitation rate. The original renewal assumed the new mental health benefits would be available for the entire year in P2 (CY 2016), so no program adjustment was necessary in P3 (CY 2017) of the original renewal.

The $3.34 PMPM increase to Aggregate PMPM Effect of State Plan Service Adjustment is from adding back the $3.51 PMPM program adjustment to arrive at the full benefit cost of $7.05 PMPM and then deducting the $0.17 PMPM reduction to inflation due to lower benefit cost.

The $5.96 PMPM decrease to Total PMPM State Plan Service Cost Projection is the $5.79 PMPM cost reduction from removing outpatient mental health services with the $0.17 PMPM reduction from lower

inflation.

P4: The $5.96 PMPM decrease to PMPM State Plan Service Costs, PMPM Total Actual Waiver Costs, and PMPM State Plan Service Cost Projection are all carried over from the P3 (CY 2017) changes.

The $0.17 PMPM decrease in the PMPM Effect of Inflation Adjustment adds one more year of inflation at 2.9% to the $5.96 PMPM cumulative effect of removing the outpatient mental health benefits through P3.

The result is a $6.13 PMPM decrease in the Total PMPM State Plan Service Cost Projection. This represents the $5.79 PMPM benefit cost decrease in P2 (CY 2016) relative to the original renewal plus the cumulative effect of the inflation adjustment reduction compounded for two years at 2.9% annually ($0.17 PMPM +$0.17 PMPM = $0.34 PMPM).

P5: The $6.13 PMPM decrease to PMPM State Plan Service Costs, PMPM Total Actual Waiver Costs, and PMPM State Plan Service Cost Projection are all carried over from the P4 (CY 2018) changes.

The $0.18 PMPM decrease in the PMPM Effect of Inflation Adjustment adds one more year of inflation at 2.9% to the $6.13 PMPM cumulative effect of removing the outpatient mental health benefits through P4.

The result is a $6.31 PMPM decrease in the Total PMPM State Plan Service Cost Projection. This represents the $5.79 PMPM benefit cost decrease in P2 (CY 2016) relative to the original renewal plus the cumulative effect of the inflation adjustment reduction compounded for three years at 2.9% annually ($0.17 PMPM +$0.17 PMPM + $0.18 PMPM = $0.52 PMPM).

NOTE:

Administration cost trends are based on the benefit inflation adjustment. The new inpatient mental health benefit is included in P2 (CY 2016) as a $3.54 PMPM program adjustment ($7.05 PMPM benefit cost less $3.51 PMPM adjustment to remove cost for the first half of the year when the benefit was not available). Adding the new benefit does not affect the P2 (CY 2016) benefit inflation adjustment, so P2 (CY 2016) administration is unchanged.

The $3.51 PMPM program adjustment made in P2 (CY 2016) to reflect the new mental health benefit being available for only a partial year, beginning 7/1/2016, is added back in P3 (CY2017) since the new benefit will be available for the entire year. Because the program adjustment is added back the following year, there is a $0.10 PMPM ($3.51 PMPM x 2.9%) inflation effect which increases the CY2017 benefit inflation adjustment factors by 0.003% for the Nursing Home Level of Care MEG and 0.017% for the Non-Nursing Home Level of Care MEG. Administration costs increase by the same factors, since administration cost trends are based on the benefit inflation adjustment. Due to rounding in the Excel workbook, the small changes to the State Plan Inflation Adjustment and Administration Costs Inflation Adjustment columns are not visible.

Administration cost increases in P4 (CY 2018) and P5 (CY 2019) are the effects of the P3 (CY 2017) increase carried forward in the base administration cost. Inflation adjustment factors in P4 (CY 2018) and P5 (CY 2019) are unchanged.

Section D: Cost-Effectiveness

Part I: State Completion Section

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in Section D.I.I and D.I.J above.

Please refer to sections D.I.J.a.i., D.I.J.a.ii., D.I.J.b.2.v.D, D.I.J.c.2.ii.D and D.I.J.e. in the pre-print for detailed explanations of the adjustments.
Appendix D5 – Waiver Cost Projection

Section D: Cost-Effectiveness

Part I: State Completion Section

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in Section D.I.E. above.

Appendix D6 – RO Targets

Section D: Cost-Effectiveness

Part I: State Completion Section

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in Section D.I.E.c & d:

   Member months are expected to increase in existing Family Care counties due to growth that has historically been experienced in counties after Family Care becomes an entitlement. Additional program growth is expected beginning in P1 (CY2015), and continuing through the waiver period, when seven counties are expected to begin operating the Family Care program. Further growth is expected in P2 (CY2016) when Rock county begins to operate the Family Care program. Adams, Florence, Forest, Oneida, Taylor, and Vilas counties in are assumed to begin operating the Family Care program during P3 (CY2017). Finally, Dane county is assumed to begin operating the Family Care program in P4 (CY2018). Program expansion is reflected in the Implementation Plan in Section A Part I D.2.

   The member month projections are based on PIHP business plans, historical trends in Family Care enrollment, and county-specific populations. Approximately 6,600 home and community based-waiver enrollees and 2,100 persons on the waiting list for long-term care services are expected to gradually transition into Family Care. The transition periods for counties with existing home and community-based waivers range from one to seven months. Persons on a waitlist are assumed to be enrolled evenly over 36 months. Roughly 67% of people are assumed to enroll in the Family Care program with the other 33% enrolling in the Self-Directed 1915(c) waiver option. When the program becomes an entitlement in a county beginning in month 37 after program operations begin, historical enrollment shows annual growth rates of approximately 12% in a county's first year of entitlement, 11% in the second, 9% in the third, and 2% thereafter.

   Family Care member months are expected to increase by 5.2% from R2 to P1, 5.9% from P1 to P2, 4.1% from P2 to P3, 6.1% from P3 to P4, and 3.0% from P4 to P5.

   The transition period assumptions above are preliminary and are intended to be used for budgeting purposes only. Actual transition periods will be determined upon consultation with PIHPs, counties, ADRCs, and other interested parties after PIHP contracts have been awarded.
2. Please explain unit cost changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in Section D.I.I and D.I.J:

   Standard actuarial practices are used to in developing the trend factor for Family Care. Using historical service data (in this case, data from CY 2011 – CY 2013), PricewaterhouseCoopers "backs out" the known cost increases associated with any PMPM changes, by service category. Any remaining change in the PMPM is assumed to be utilization change. This utilization change over the period is then used to predict utilization change in the future.

   Medicaid unit cost increases may be known in advance, if the State Legislature has passed the relevant legislation. In those cases, the unit cost increases can be added into the capitation rate development in advance. (This is appropriate because the Family Care PIHPs typically rely on the Medicaid fee schedule.) If the Legislature acts after capitation rates have been developed, however, the rate increases may be added to the capitation rate in a retrospective adjustment.
3. Please explain utilization changes contributing to the overall annualized rate of change in Appendix D7 Column I. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in Section D.I.I and D.I.J:

   A separate adjustment for utilization change is not included.

b. Please note any other principal factors contributing to the overall annualized rate of change in Appendix D7 Column I.

Due to technical limitation of the WMS, please refer to this section in the pre-print.

The following program adjustments are included:

An adjustment of -0.13% was made to NH LOC and 0.11% to Non-NH LOC in P1 (CY2015) to reflect payments and recoveries reported in the CMS 64.9 for R1 and R2, but need to be excluded in projected future periods as these costs will not be incurred again in the projection period.

Enrollment changes in PIHPs serving existing Family Care counties affect the average program-wide capitation rates. This adjustment relates to the effect of PIHPs with different capitation rates having different enrollment growth rates. The aggregate capitation rate will increase if there is more enrollment growth MCOs with higher capitation rates and will decrease if enrollment is higher in MCOs with lower capitation rates. The impact of enrollment in counties implementing Family Care is described in a separate program adjustment. Adjustments to NH LOC are -0.47% in P1 (CY 2015), -0.18% in P2 (CY 2016), -0.31% in P3 (CY 2017), 0.08% in P4 (CY 2018), and -0.33% in P5 (CY 2019). Adjustments included in Non-NH LOC are -0.66% in P1 (CY 2015), -0.12% in P2 (CY 2016), -0.12% in P3 (CY 2017), -0.11% in P4 (CY 2018), and -0.11% in P5 (CY 2019).

An adjustment of 0.75% was needed to NH LOC for P1 (CY 2015) to compensate for a one time policy adjustment made to R2 (CY 2014) rates for one PIHP. The PIHP made changes to its operating structure that cut costs dramatically and would have resulted in excessive profits. Capitation rates were reduced for the year and PIHP was required to use the surplus to re-establish certain program operations that had been cut.

Family Care program expansion to additional counties requires NH LOC adjustments of 0.23% in P1 (CY 2015), 0.36% in P2 (CY 2016), -0.10% in P3 (CY 2017), 0.43% in P4 (CY 2018), and -0.20% in P5 (CY 2019). Expansion related adjustments for Non-NH LOC are 0.00% in P1 (CY 2015), 0.00% in P2 (CY 2016), 0.00% in P3 (CY 2017), 0.00% in P4 (CY 2018), and 0.00% in P5 (CY 2019). The adjustments are the result of the case mix of the population in new implementation areas being added to the existing rate structure. Members enrolling from the wait list typically have lower acuity which suppresses any rate increases that would otherwise occur. Rates in newly implemented counties include a phase-in adjustment during the first 24 months that a county is transitioning to Family Care. The incentive decreases by 50% in months 13-24 and is removed completely after month 24.

Consultative Clinical and Therapeutic Services for Caregivers and Training Services for Unpaid Caregivers will be added as new home and community-based benefits 1/1/2015 adding $0.54 PMPM to the NH LOC capitation rates. An adjustment of 0.02% is included in P1 (CY 2015).

Nursing home supplemental payments will not be made to PIHPs on or after 1/1/2015. The payments are included in the 9/30/2014 CMS 64 requiring a -0.16% adjustment to the NH LOC in CY2015. Historically, nursing home supplemental payments are authorized under s.49.45(6u), Wis Stats, in which the legislative intent regarding the purpose of the payments is made explicit at 49.45(6u)(am):

> *Notwithstanding sub. (6m), from the appropriations under s. 20.435 (4) (o), and (w), for reduction of operating deficits, as defined under the methodology used by the department in December 2000, incurred by a facility that is established under s. 49.70 (1) or that is owned and operated by a city, village, or town, and as payment to care management organizations, the department may not distribute to these facilities and to care management organizations more than $39,100,000 in each fiscal year, as determined by the department. The total amount that a county certifies under this subsection may not exceed 100% of otherwise-unreimbursed care.*

Payments for high cost relocations have not yet been made to the PIHPs and have, therefore, not yet been reported on the CMS 64 requiring an adjustment of 0.72% to the NH LOC in P1 (CY 2015). These payments will be reported on future CMS 64s when the payments are made or incorporated into the capitation rates. Once the payments are added to P1 of the projection, they are automatically included in the cost base for future years, so no other adjustments are needed.

Money Follows the Person incentive payments were reported in the 6/30/2014 CMS 64 and will continue to be made in the future. Therefore, no policy adjustment is needed in the projection.

Funding is included in P1 (CY 2015) for adjustments to CY2015 capitation rates for PIHPs experiencing disproportionately high costs relative to the capitation rate model. These are contingent expenditures to stabilize PIHPs experiencing financial distress. There have been three PIHPs that have discontinued operations since 2008 that required additional funding. Four PIHPs are likely to be placed on either heightened financial monitoring or financial corrective action by the end of CY2014. Detailed review has indicated that PIHPs' operations to be the primary source of the financial difficulties, not the soundness of the capitation rates. The PIHPs are required to identify and implement efficiencies to reflect the payment model and will continue under enhanced financial monitoring, which includes monthly financial reporting. Additional funding would be incorporated into capitation rates. Contract amendments would be executed if the rate adjustments occur after the initial contract for year is signed. These costs are not reflected in the CMS 64 reports through 6/30/2014 requiring a policy adjustment of 0.54% in P1 (CY 2015). This funding is discontinued

in P2 (CY 2016) resulting in a downward adjustment to NH LOC of -0.53%.

Net program adjustments in the NH LOC MEG are 1.5% in P1, -0.4% in P2, -0.4% in P3, 0.5% in P4, and -0.5% in P5.

Net program adjustments in the Non-NH LOC MEG are -0.6% in P1, -0.1% in P2, -0.1% in P3, -0.1% in P4, and -0.1% in P5.

Appendix D7 - Summary